Australian & New Zealand Society Of Pediatric Dentistry

NEWSLETTER

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IN THIS ISSUE

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PRESIDENT'S MESSAGE

On behalf of the Society I wish all members a successful 1989. In the following two years the Federal Council will be Dr. Peter Gregory, Vice President; Dr. Alain Middleton, Dr. Joe Vesco, Dr. Kim Seow and the Immediate Past President, Dr. Bruce Tidswell.

I must express the Society's gratidtude to Bruce for his efforts and energy as President for the last two years. Bruce's experience in the field of Paediatric Dentistry is immense and this knowledge and experience will continue to be invaluable to this Council.

At the Brisbane Conference the Society established both a Policy Committee under the Chairmanship of Dr. John Brownbill and a Public Relations Committee under the Chairmanship of Dr. Joe Verco. Both these Committees have started to function and in the June Newsletter it is hoped that some of the policies will be published and a public relations review presented.

Finally I would like to thank Dr. Kim Seow and her Committee for their efforts in making the Brisbane Conference so successful.

James Lucas
President

SECRETARY'S REPORT

The $2,961.81 profit from the 7th Biennial Conference in Brisbane is now safely in our bank account, which is just as well, as so far I have received no 1989 subscriptions which are due each year on January 1st. (State Secretaries plese take note.)

I have also in my possession a limited number of registration forms for the June I.A.D.C. Convention in Athens. If any member would like one would he/she please contact me.

On the agenda for the I.A.D.C. Council meeting is a motion to change the Society's name to "The International Association of Paediatric Dentistry". It seems we have set the fashion.

I still have no news from the New Zealand potential members, but I believe the wheels have been set in motion for them to join us this year.

John Keys
Secretary

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EDITOR'S REPORT

The Editor apologizes for the failure of the December issue to appear, but during the forthcoming year production schedules and the obtainment of lead articles will hopefully improve so that four issues will appear.

The popular columns from John Burrows will keep us abreast of the other scientific journals but it is envisaged that overseas editorial will be brought before the membership to indicate what controversies are being discussed overseas.

John Brownbill has been appointed Assistant Editor and his assistance and wisdom will be welcome.

Any member who has a clinical case or matter of interest for publication, please forward this to the Editor.

Editor

LETTER TO THE EDITOR

I was most pleased to see a clinical problem featured in the last issue of the A.S.D.C. Newsletter. I applaud this idea and congratulate Dr. Cameron on his excellent presentation of the problem.

I would, however, like to raise several points - the first concerning Dr. Cameron's discussion and management of the patient where he mentions "**A general anaesthetic is contraindicated in this case** due to the possible laryngeal complications and so the submerged teeth must be left and observed".

Over the past 25 years at the Royal Children's Hospital we have operated under endotracheal general anaesthetsia on almost 30 children with Empidermolysis Bullosa Hereditaria (E.B.H.). No laryngo-tracheal complications were found following specialist paediatric anaesthetic intubation of these children and I would like to draw members' attention to a paper in Anaesthesiology Vol 56:323-326 published in 1982 by I. James and H. Wark. Their review of 33 children from the Hospital for Sick Children, Great Ormond Street, London (1958-80), corresponds very closely with ours.

In our view, the advantages of endotracheal intubation (preferably nasotracheal) for oral procedures in E.B.H. patients (giving both anaesthetist and dental surgeon complete control and no time constraint, thus permitting virtually all types of minor oral surgery and restorative dentistry) far outweigh the theoretical problems of possible airway embarrassment from bullus formation, which have been shown not to be a significant complication with specialist paediatrician anaesthetic management in a paediatric hospital environment.

There are other problems of course for the dental surgeon operating on these children whether under general or local anaesthesia, as bullus formation and stripping of surface layers of the oral mucosa occurs with finger or instrument contact. The use of copious quantities of vaseline gauze prevents this. Whilst extremely messy, the vaseline gauze is an effective aid to management, (being replaced as frequently as necessaruy) both in the mouth and covering the lips and facial skin wherever gloved fingers or instruments may contact the tissue. The alternate method used to prevent mucosal detachment is to use well lubricated full mouth rubber dam. (Endruschat and Keenan, Oral Surg. 36:667-71: 1983).

Finally, the relationship of Epidermolysis Bullosa and Amelogenesis Imperfecta, has been discussed by Arwill et al (oral Surg. 19:723-44 1965). They suggested a close relationship between the two conditions (in which non-chronological developmental defects of enamel are present in all teeth) on the basis of the globules on and above the enamel surface held as a conglomerate by the reduced enamel epithelium. These are seen in the enamel in E.B.H. of both dystrophic and legalis forms and are similar in appearance histologically to the enamel defects seen in hypomineralized amelogenesis imperfecta.

I hope that these additional comments on E.B.H. and A.I. are of some interest to members and once again congratulate Dr. Angus Cameron on his presentation of this most interesting case.

Roger K. Hall,
Director, Department of Dentistry,
Royal Childrens Hospital, Melbourne

OBITUARY

Professor Emeritus Elsdon Storey, ED, BDSc, MDSc, PhD, DDs, FICD

Professor Elsdon (Tony) Storey died peacefully at his home in Melbourne on October 10, 1988 after retirement earlier in the year. Tony Storey's association with the University of Melbourne spanned over more than 40 years. He completed his dental course in 1945, and after a period of service in the Army he was appointed to the Orthodontic Department of the Dental Hospital of Melbourne. He maintained his links with the Army up until the time of his retirement, reaching the rank of Lieutenant Colonel. His first teaching appointment in the Australian College of Dentistry was in 1948. His early research activity involved the development of ingenious methods for the measurement of orthodontic forces, and it was largely because of this curiosity that a shift took place in orthodontics from the use of high spring forces to the current concepts of light forces.

By 1954 he had completed MDSc and DDSc degrees and shortly afterwards he went to U.K. on a Nuffield Scholarship where he completed a PhD degree with Sir Roy Cameron. He returned to Australia and commenced working as a Research Fellow in the Department of Pathology in the University of Melbourne. In 1963, he was appointed to the Chair in Conservative Dentistry at a time when the Dental School moved from the Spring Street Hospital to its current site. In 1974, he moved sideways to be the first occupant of the newly created Chair of Child Dental Health - a move which identified with its expressed ideals of the need to promote improved dental health for children in the community. He was a Senior Consultant to the Royal Dental Hospital of Melbourne from 1963 to 1988 and Dean of the Faculty of Dental Science on two separate occasions, 1971-78 and 1980-81.

From his earliest academic days Tony Storey was a tireless advocate for the prevention of dental disease in childhood. He was a major force in the promotion of water fluoridation contributing substantially to the Tasmanian Government's Committee of Inquiry into Water Fluoridation and later, the Victorian Government's Committee of Inquiry. His scientific logic and persistence was rewarded in 1977 by the introduction of fluoridation in Melbourne. He continued in his efforts to make

available the benefits of water fluoridation to other Victorian cities and towns up until the time of his retirement due to ill health.

Tony Storey was also a strong community advocate for the improved nutrition of Victorian children. He contributed to the development of the Australian Nutrition Foundation and its policy on dental health and school canteens. By stimulating industry to concern itself with dental research and dental health promotion Tony Storey was instrumental in arranging for the Victorian Milk Board (now the Victorian Dairy Industry Authority) to make substantial financial commitment both to resourcing dental nutrition information to schools and the community, and also for the study of anti-decay factors in foods. The active and productive research in the Department of Preventive and Community Dentistry is an on-going testimony to Tony Storey's drive and initiative in applied dental science research.

Tony Storey was one of the founders of the Australian Section (now the Australian and New Zealand Division) of the International Association for Dental Research. Throughout his career, his interest in research activity was always paramount, and it is largely because of his influence that research has come to play such an important role at both undergraduate and graduate levels in the Melbourne Dental School. His personal research into bone metabolism, fluorides, and the antidecay properties and that of his many graduate students had many practical applications of direct benefit to Victorian children while at the same time receiving international recognition for its academic and scientific merit. Over his career he published over 80 learned articles in the international literature and contributed to three textbooks.

Earlier this year, Tony Storey's contribution to the dental profession over so many years was recognized by the presentation of the Award for Distinguished Service from the Australian Dental Association (Victorian Branch) - the Association's highest Award.

Tony Storey was a family man and a very talented painter. He tried many different styles and methods of painting, and was equally proficient with landscapes and with portraits.

He is survived by his wife Dr. Pat Gladwell and his three sons. To them and his two daughters-in-law must be expressed the thanks of the University and dental profession for a life of service and dedication which has achieved so much and has influenced so many others to emulate his example. He will be sadly missed.

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DISCUSSION PAPER

"O R A L H Y G I E N E A D V I C E"

"IS IT A WASTE OF TIME FOR CHILDREN?"

(Thomas J. Higgins, Staff Specialist Periodontics, The Royal Dental Hospital of Melbourne and Richard Widmer, Head of Pedodontics, Westmead Dental Clinical School)

The primary goals of Dentistry and the Dental Profession in Australia today, is the prevention of all forms of oral diseases and the maintenance of oral health. As confirmation of the success of these goals, studies that have examined the dental caries status of young Australians (up to 12 years of age) show a dramatic increase in the percentage of children with no experience of dental caries. In addition for those children and adults who have suffered, or in the future may suffer from dental diseases, modern materials and techniques have assisted the profession in restoring the diseased or damaged oral cavity to health. These advances, particularly in primary and secondary preventative measures, have come about because ther is now a much greater understanding of the factors involved in the aetiology of dental diseases. However, it must be recognised with respect to dental caries, periodontal diseases and oral neoplastic changes, that there are often many factors that make up the complex aetiological profile of these diseases. For example, the multifactorial aetiology of dental caries embraces the components of saliva, the micro-organisms of dental plaques, the status of the hard tooth surfaces and in our multicultural society, a diversity of nutritional substrates prepared in a miriad of ways. All these components in dental caries aetiology must be noted and taken into account when examining the individual's dental caries experience and determining both individual and community-based preventive programmes.

There is no argument that the common factor in terms of the aetiology of both dental caries and periodontal diseases is the microbial dental plaque. However, while it is obvious, it should be remembered that the sites of lesion development in the oral cavity for these two diseases are quite different. Possibly the only time the common aetiological factor, dental plaque, comes together best for these two diseases is with respect to root surface caries and the associated gingivitis.

Since microbial plaque is the common link, the concept that removal of the deposits from the tooth surfaces and the gingival margin will therefore lead to the prevention of the disease process is soundly based.

However, with this information some problems can be observed. Individuals have to carry out these procedures throughout life on a regular basis. It is not only the physical removal of dental plaque that is important but also it is the quality of the

cleaning process. When outlining these problems associated with plaque removal, it must be noted that many sites (tooth fissures, interproximal areas) are poorly cleaned by the conventional methods, particularly if cleaning is carried out in a haphazard manner.

These problems are, in the author's view, best discussed when the following question is posed:

> "What role is there for Oral Hygiene Instruction in the prevention of dental diseases in children?"

The answer is complex and in formulating the response it is possible to include quite opposite terms such as, "very little use" and "of great significance". For example, oral hygiene instruction for children is of "very little use" because of the lack of manual dexterity the children often exhibit. However, oral hygiene instruction for children is of "great significance" for it introduces a child to the concepts of long term health promoting procedures. How can we have such opposite responses to this question? The answer comes from carefully studying in a scientific manner our believe and knowledge of the role in the prevention of oral diseases. For too many dentists the basic beliefs about oral hygiene in particular toothbrushing and its relationship to dental caries, has become a well-rehearsed dogma that is infrequently reviewed. Twenty-three years ago Bibby (2) explored the understanding the profession had about what he called the Triad: Oral Hygiene, Proper Diet and Regular visits, and suggested that comments so loosely made by dentists and their staff about those components of the triad for oral health care were not based upon scientific fact. Frequently you hear that the positive endorsement of oral hygiene, in the form of better toothbrushing, will assist in dental caries reduction. Often this is a throw-away line during a relatively short dental examination for a child. What is the evidence for this statement?

A. SELF-PERFORMED ORAL HYGIENE

When this relationship between dental caries status and oral cleanliness or reported frequency of toothbrushing has been reviewed, the general consensus from these studies is that mechanical oral hygiene does not prevent dental caries (3,4).

Why is this the case? Because there are so many factors that influence dental caries development. It is nearly impossible to design an experiment that eliminates most of these factors to allow mechanical plaque removal and dental development to be the only variables. In addition, toothbrushing does not clean into fissures or the interproximal surfaces of teeth. With the quality of toothbrushing, very few studies have ever provided any significant proof that good performers of oral hygiene have less dental caries. Tucker et al (5) showed a small reduction in caries increment in children during a three year clinical trial. The reduction was confined to those children who were "good" at oral hygiene which was determined by a final examination

questionnaire. The statistical significant differences were limited to teeth that erupted during the study period.

The clinical experience of dentists does suggest that certain locations, subject to efficient hygiene such as the labial and buccal surfaces, may exhibit less dental caries. However, self performed oral cleaning has not been effective in preventing caries.

An additional question related to self performed oral hygiene is:

> When is a child ready to be responsible for his or her own dental health?

The first limiting factor is the manual dexterity of the child and then the second, the ability of the child to understand and accept responsibility for their own oral health. From McClure's study of young children (6) it was noted that dentists must communicate with the parents the techniques for oral cleanliness. In this way the responsibility for the health of the mouths of their children is shared between the dentist and the parent. Nowak(7) suggested that it is the dentist's responsibility to provide the parents with comprehensive educational programmes whereby the parents are able to instruct the child in oral health maintenance. Interestingly, whenever oral health programmes have been introduced into the school environment, the long term benefits have been poor in non-fluoridated communities, regarding dental caries increment(8) and gingivitis scores(9).

B. PROFESSIONAL TOOTH CLEANING

Whenever professional tooth cleaning on a regular basis was added to the studies of oral hygiene and dental caries the results were very good(10). The addition of fluorides in their various forms, as in the Karlstad preventive programmes of Axelsson and Lindhe(11), produced dramatic reduction in the caries increment of the test subjects. These studies showed how important the professional tooth cleaning was and the benefits of meticulous plaque removal. When this professinal cleaning weas replaced by supervised self performed oral hygiene much of the caries prevention effects were lost(12). These studies showed that efficient oral hygiene which can be carried out professinally is a caries preventive measure. However oral hygiene practices are, in our society, home based. To expect that children and parents will consistently be highly motivated in both toothbrushing and interdental cleaning may be placing too much emphasis on these procedures. The preventive results of which are not well supported in the scientific literature.

In conclusion: the answer to the question posed in the title of this short article lies in our ability to correctly outline to our child patients and their parents the expected benefits of oral hygiene in a caries preventive programme. In our society today toothcleaning with a fluoride containing toothpaste is usual practice and is effective in reducing the incident of dental

caries. However casual comments on the expected positive preventive benefits of self performed tooth cleaning are unacceptable if provided in isolation as a preventive measure. Rather, we as dentists and our staff need constantly to be on our guard to provide the correct advice for the prevention of dental caries.

Additional scientific knowledge during the past 20 years has supported the triad of Oral Hygiene, Proper diet and Regular visits as cornerstones of preventive programmes. However, not applied in a haphazard fashion to all our patients as a boring repetitive dogma. Rather the triad should be prescribed for each individual and family in various combinations throughout life to provide health maintenance, the ultimate goal of all dental care.

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DENTAL RADIOGRAPHIC EXAMINATIONS

(Reprinted from
U.S. Department of Health and Human Services Pamphlet)

When, and for Which Patients, Should You Perform a Dental Radiographic Examination?

Articles in the dental literature have questioned the scheduling of dental radiographs on a routine basis because such scheduling does not take into account the differing signs and symptoms of patients. The question arises whether the results of routine radiographic examinations contribute to patient management; if not, such routine scheduling results in unnecessary patient exposure.

To assess the proper use of radiographs in dental care, a panel of dental experts was convened under the sponsorship of the Food and Drug Administration's Center for Devices and Radiological Health, to review the literature and other clinical evidence on the utility of dental radiographic examinations. The panel, representing general dentistry, periodontics, pediatric dentistry, oral medicine, and dental radiology, developed the prescription strategy presented here. The strategy contains guidelines that will assist the dentist in deciding when a radiograph is appropriate. The panel emphasizes that the guidelines are voluntary; they are intended to aid the judgement of the dental practitioner, not to supersede it.

How to use this Prescription Strategy

The panel strongly endorses the concept that a history should be taken and a clinical examination of the patient should be completed prior to deciding whether dental radiographs should be made.

Once it has been determined that radiographs are needed, three decisions must be made.

- Determine whether the patient presenting for dental care is making a new or a recall visit.

- Categorize the patient by chronological age and by developmental stage or dental status, i.e. child (primary or transitional dentition); adolescent; or adult (dentulous or edentulous).

- Assign the patient to a risk category based on history and clinicl signs and symptoms. The risk categories are: clinical caries or high risk factors for caries; no clinical caries and no high risk factors for caries; and periodontal disease or a history of periodontal treatment. A category for assessment of growth and development is also included.

After making these decisions, read the appropriate guideline from the chart. Because the patient's condition may change over time, it is necessary to periodically reconsider the type of visit, age category, and/or risk group.

REMEMBER - THIS PRESCRIPTION STRATEGY NEITHER PRECLUDES NOR REQUIRES DENTAL RADIOGRAPHY WHEN YOUR CLINICAL JUDGEMENT SUGGESTS OTHERWISE.

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GUIDELINES FOR PRESCRIBING DENTAL RADI[illegible]HS

(The recommendations in this chart are subject to clinical judgement and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. The recommendations to not need to be altered because of pregnancy.)

PATIENT CATEGORY	CHILD		ADOLESCENT		
	Primary Dentition (prior to eruption of first permanent tooth)	Transitional Dentition (following eruption of first permanent tooth)	Permanent Dentition (prior to eruption of third molars)	Dentulous	Endentulous
NEW PATIENT* All new Patients to Assess Dental Diseases and Growth and Development	Posterior bitewing examination if proximal surfaces of primary teeth cannot be visualized or probed.	Individualized radiographic examination consisting of periapical/occlusal views & posterior bitewings or panoramic examination & posterior bitewings	Individualized radiographic examination consisting of posterior bitewings & selected periapicals. A full mouth intraoral radiographic examination is appropriate when the patient presents with clinical evidence of generalized dental disease or a history of extensive dental treatment.		Full mouth intraoral radiographic examiantion or panoramic examination.
RECALL PATIENT* Clinical caries or high-risk factors for caries**.	Posterior bitewing examination at 6-month intervals or until no carious lesions are evident		Posterior bitewing examination at 6-12 month intervals or until no carious lesions are evident	Posterior bitewing examination at 12-16 month intervals.	Not applicable
NO Clinical caries and no high-risk factors for caries**	Posterior bitewing examination at 12-24 month intervals if proximal surfaces of primary teeth cannot be visualized or probed	Posterior bitewing examination at 12-24 month intervals	Posterior bitewing examination at 18-36 month intervals	Posterior bitewing examination at 24-36 month intervals	Not applicable
Periodontal disease or a history of periodontal treatment	Individualized radiographic examination consisting of selected periapical and/or bitewing radiographs for areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.		Individualized radiographic examination consisting of selected periapical and/or bitewing radiographs for areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically		Not applicable
Growth and Development Assessment	Usually not indicated	Individualized radiographic examination consisting of a periapical/ occlusal or panoramic examination	Periapical or panoramic examination to assess developing third molars	Usually not indicated	Usually not indicated

*Clinical situations for which radiographs may be indicated include:
A. Positive Historical Findings
1. Previous periodontal or endodontic therapy.
2. History of pain or trauma anomalies
4. Postoperative evaluation of healing
5. Presence of implants
B. Positive Clinical Signs/Symptoms
1. Clinical evidence of periodontal disease
2. Large of deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of facial trauma
7. Mobility of teeth
8. Fistula or sinus
9. Clinically suspected sinus pathology
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects.
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or colour
21. Missing teeth with unknown reason.

**Patients at high risk for caries may demonstrate any of the following:
1. High level of caries experience
2. History of recurrent caries
3. Existing restoration of poor quality
4. Poor oral hygiene
5. Inadequate fluoride exposure 6. Prolonged nursing (bootle/breast)
7. Diet high sucrose
8. Poor family oral health
9. Enamel defects
10. Developmental disability
11. Xerostomia
12. Genetic abnormality of teeth. 13. Many multi-surface restorations
14. Chemo/radiation therapy.

POLICY COMMITTEE SET UP

The Australia and New Zealand Society of Paediatric Dentistry has set up a Policy Committee. The Convenor, John Brownbill, and the President James Lucas have invited a member from each State to serve with them to prepare a policy document.

The Policy Committee is a consensus and ACTION Committee. Menbers have been invited to make submissions which will be copied and distributed. Each will be asked to distil the submissions into a draft document for further distribution. Individuals then will be asked to fine hone sections as appropriate until consensus occurs. Deadlines have been set so that the job is done quickly and interest is not lost. The completed document will be sent to the Federal Committee by 3rd April 1989.

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BRANCH NEWS

NEW SOUTH WALES

The A.N.Z.S.P.D. New South Wales Branch held its 11th Annual General Meeting and its 53rd General Meeting on Tuesday 6th December, 1988.

Election of Office Bearers for 1989 were as follows:-

President	Dr. Richard Widmer
Treasurer	Dr. Angus Cameron
Secretary	Dr. Kathryn Amenan
Committee Members	Dr. Maurice Hunoitz
	Dr. Judy Fenton
	Dr. Yvonne Sum
	Dr. Peter Wong
	Dr. Alain Middleton

Our guest speaker for the evening was Ms. Loretto Giorcelli, Education Officer for The Education Department and President of the Australian Deafness Council. She spoke on "Aspects on Dealing with Disabled Children and Adults". She defined the terms 'Profoundly Deaf' vs 'Hearing Impaired' and introduced the group to sign language.

24 members and guests attended the dinner meeting and the evening went very well.

Judy Fenton
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QUEENSLAND

President's Report 1988:

This has been a very special year for our Society which hosted the 8th ASDC National Biennial Conference, aptly named the Bicentennial Conference here in Brisbane in October. I am pleased to reportthat it was extremely successful with well over 70 participants from all over Australia. From their feedback, it was apparent that most of them found the Scientific Programme excellent and the general organisation pleasing. The Conference dinner, held at Roseville Restaurant, was also a great success with everyone in high spirits.

I thank the Conference's Organising Committee for their excellent teamwork and tremendous personal contribution without which the Conference would not have proceeded so smoothly - Paul Killoran, Laurie Bourke, Kerrod Hallett, Bill Wilson, John Keys and Tom Condon.

I am very pleased to announce that so successful was our Conference that we have a cheque of over $4,700 to present to the Federal Branch as money left over from the Conference.

Throughout the year, we have had several successful meetings with excellent guest speakers who enlightened us on aspects of paediatric dentistry in other specialities - Dr. Irene Apel, Child Psychiatrist; Dr. Greg Seymour, Periodontist; and Dr. Rod Auer, Orthodontist.

During our bi-monthly meetings, membership continued to grow and increasing interest in the Society has been evidenced by frequent guests attending. The ASDC prize, awarded to the best student in Dentistry for Children at the University of Queensland continues to generate interest in the Society and in 1987 was awarded to Dr. Spiros Sclavos.

The Annual General Meeting of the Branch was held on 28th November 1988 at the United Services Club. Election of Office Bearers for 1989 resulted in:

President	Dr. Laurie Bourke
Secretary/Treasurer	Dr. Paul Killoran
Committee Members	Dr. Lynn McAllan
Federal Delegate	Dr. K. Seow

I take this opportunity to thank all members of my Committee for their help in 1988 - Paul Killoran for his untiring efforts as Secretary and Treasurer; Bill Wilson as Committee Member and John Keys as Federal Representative.

I wish the Society well for the future years.

W. Kim Seow - President

SOUTH AUSTRALIA

The final meeting for 1988 of A.S.D.C. (SA Branch) was held on Tuesday 18th October 1988 at the Feathers Hotel, Burnside. The change of venue proved most successful, thanks to our President's superb choice of foods and wines.

Our Guest Speaker was Dr. Ross Macdonald, a specialist in dento-maxillo-facial radiology. His talk covered a wide range of aspects of dental radiology. He saw the use of radiographs in children as essential to follow up existing disease; to monitor endodontic management of primary teeth and unresolved pathology and to assess abnormal resorption patterns.

Dr. Macdonald spoke also on current and anticipated advances in dental radiography machines and films with emphasis on the reduction of exposure times to one hundredth of a second within a few years. He completed the evening with a short section on reading radiographs. Our members were most appreciative of his efforts on the night and his time spent answering questions from the group.

At the conclusion of the meeting, the President Jeff Wright, spoke of final plans for the S.A. Branch's Midwinter Convention to be held in the Clarendon McLarent Vale Wine District on Friday and Saturday 11 and 12th August, 1989. A warm invitation is extended to interstate readers and members who will be assured of an excellent weekend for body, mind and spirit. For further information please contact:

Jeff Wright	320 Greenhill Road, Glenside 5065 Tel: (08) 79.6627
Meredith Fantham	18 Philip Avenue, Leebrook 5068 Tel: (08) 332.6397

Meredith Fantham

VICTORIA

The Victorian Branch held its final dinner meeting for 1988 in September, and members were presented with an informative lecture from Dr. Hans Keur - supported by dual projection - elucidating on "What my OPG tells me".

The Annual General Convention Day was held in conjunction with the Victorian Branch of the Australian Society of Endodontology on 19th October 1988 at the Southern Cross Hotel. Drs. Jens and Frances Andreasen presented a stimulating series of lectures on the following topics:

A. The effect of repositioning and splinting after luxation injuries.

B. Recent treatment procedures for crown and crown/root fractures.
C. Root resorption - how to stop the osteoclast.
D. Autotransplatnation.
E. Surgical Endodontics.

The day proved very successful with 169 dentists in attendance.

The A.G.M. was held on 2nd December 1988 at the home of Sophie and Robert Feik. A most enjoyable dinner and evening followed on from the meeting which included active participation from members present in discussion of Branch business. The following Office Bearers were elected for 1989:

President	Dr. Chris Olsen
Vice President	Dr. Leith Brown
Secretary/Treasurer	Dr. Mary Ellen Wilkinson

An interesting programme has been set for 1989 and will commence on February 23, 1989 with Professor Mark Wahlqvist from Monash University presenting the Inaugural Professor Elsdon Storey Memorial Lecture at the first dinner meeting for the year. His topic will be "Nurtirion, Medicine and Dentistry".

The Victorian Branch wishes other Branches of the A.N.Z.S.P.D. a successful 1989 and welcomes its new Tasmanian members.

Leigh Pagonis

WESTERN AUSTRALIA

The activities for 1988 came to a most successful conclusion with the Annual General Meeting and Dinner, held on Friday 4th November 1988 at the Trade Winds Hotel in Fremantle. A fine meal was enjoyed by all in attendance. The after-dinner speaker was Mrs. Maurice Swanson, who is Acting Director of Health Promotion Services in the Health Department of W.A. Maurice spoke about the most successful QUIT Campaign, outlining how the Department has made the most of a limited budget, a budget which pales in comparison with the budgets of those companies encouraging smoking. In addition to these pecuniary considerations, Maurice spoke of the various ways used to not only maximise the impact of their message, but to then reinforce it. Maurice then referred to their more recent Eat Less Fat Campaign, a message which was not missed by an extremely well-fed audience! A lively question period followed and a vote of thanks proposed by Dr. David Neesham was carried by acclamation.

Branch President, Dr. John Hands then outlined the proposed programme for 1989 and introduced the 1989 Committee:

President	Dr. John Hands
Vice President	Dr. John Winters
Secretary	Dr. Alistair Devlin
Federal Delegate	Dr. Peter Gregory
Committee Members	Dr. Meredith Arcus; Dr. Mark Foster

Alistair Devlin

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FROM THE JOURNALS

With John Burrow

RESTORATIONS WITHOUT CONVENTIONAL CAVITY PREPARATIONS

In many developed countries, much dental care is orientated towards restoring teeth using conventional cavity preparation designed according to principles laid down at the turn of the century by G.V. Black. While individual teeth are saved by operative treatment the success of such treatment in epidemiological terms is not great. A review of studies concerned with the prevalence of failure of restorations, as determined by a variety of workers, concluded that one in three restorations present at any one time is unsatisfactory. It is all too easy to assume that restorations are the perfect and ultimate way of managing caries. Clearly, this is not the case.

Restorative dentistry has traditionally been based upon the concept that the surgical excision of carious tissue followed by restoration of the tooth is the treatment of choice for caries. A true cure for the disease occurs only when the ionic balance between the loss and uptake of calcium and phosphate ions from the lesion can be made to swing in the overall direction of remineralization.

Although dentists are expert at diagnosing caries, it should not be taken for granted that they are infallible. It is all too easy to feel confident in planning routine restorative treatment and for practitioners to consider their prescribing patterns to be entirely justified. When 15 dentists each examined and planned treatment for the same group of 18 young adults, the number of positive treatment decisions made by the different dentists ranged from 20 to 153. The inescapable conclusion is that many of their decisions must have been incorrect. It seems clear that conventional restorations should be avoided where an alternative strategy exists.

Where there is active caries, ther are two possible treatment options that do not include conventional cavity preparations. These are :-
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1. To cause the lesion to arrest and, under certain conditions, to partially remineralize. The reader will appreciate that many carious lesions do not progress if left alone.

2. To undertake an invasive restorative procedure using an unconventional cavity preparation.

Because it is often difficult to assess accurately the presence and/or activity of small pit or fissure lesions, it is inevitable that monitoring them over time is fraught with difficulty. It is therefore inappropriate to adopt any type of watch-and-wait approach, regardless of the use that is made of home preventive measures and topical fluoride application. Even if the pit or fissure is in fact non-carious or it contains a lesion that becomes arrested, it is just about impossible to prove that this is the case. Suspicious pits and fissures should therefore be assumed to have small active carious lesions. A correctly applied fissure sealant can be expected to bring about the arresting process.

If an invasive procedure has to be undertaken, a very conservative approach should be made. Removal of caries is the primary determinant of cavity preparation and will dictate size and shape. This has to be coupled with an understanding of the need for relatively low cavo-surface angles in order to maintain enamel and achieve strong restoration margins. No attempt is made to achieve Black's somewhat artificial and highly mechanistic outline form. Sometimes it is possible to combine such cavity preparations with fissure sealants to provide "sealant restorations".

(ELDERTON R.J. International Dent Journal (1988)38,112-118)

AMALGAM REPLACEMENT: ARE OUR DECISIONS BASED ON FACT OR TRADITION

A limited number of studies have been done that document the longevity of the amalgam restoration. The maximum duration of an amalgam has been placed at 25 years while a recent study found 5% of replacement restorations were 25 to 50 years old. Failure has been attributed to three principal factors - the dentist, the materials and the patient.

Great advances have been made in modifying these three factors. With respect to the patient, emphasis on prevention and oral hygiene in dental practice has certainly increased awareness. Ongoing research has lead to improvement in the physical properties and clinical performance of dental amalgam. Despite these improvements, replacement dentistry comprises, on average, 71% of all restorative treatment delivered according to a study done in 1986 while another study done in 1984 found two-thirds of treatment was replacement.

As individuals, we are all products of our experience and those

decisions. Restorative dentistry has long been the central focus of dental practice and hence the dental curriculum. Decisions to replace restorations wer and still are straight forward if the rreaosns are associated with recurrent caries, overhangs, open contacts, fractures or inappropriate contours. However, restorations with doubtful integrity were not debated. Everything was included in treatment planning in a search for perfection. As students we are not able to see the long term results of our "perfect restoration". We must make efforts to reduce the number of replacements. Patients must be made aware that restorations at risk are being watched which may necessitate more frequent professional examination.

(BOYD MARCIA. From the Internationl Symposium:Criteria for Placement and Replacement of Dental Restorations, Orlando, Florida, October 19-21, 1987)

THOUGHTS:

Marriage has many pains, but celibacy has no pleasures
(Dr. Samuel Johnson)

Marriage is not all bed and breakfast.
(R. Coulson)

Nuptial love maketh mankind; friendly love perfecteth it; but wanton love corrupteth and embaseth it.
(Francis Bacon)

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PRINCIPAL FUNCTION DATES IN EACH STATE

July 21st	NEW SOUTH WALES An Afternoon in Paediatric Dentistry - Medical Updates for Paediatric Dental Clinicians A.N.Z.S.P.D. (NSW Branch) in association with The Childrens Hospital Camperdown
August 11 - 12th	SOUTH AUSTRALIA Mid Winter Convention Clarendon McClaren Vale Wine District
August 12 - 13th	QUEENSLAND Convention Day
September 13th	WESTERN AUSTRALIA Current Controversies in Child Patient Management
October 27th - 28th	VICTORIA Convention Day

Further information and Registration Forms in future Newsletters

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